MISSOURI

DIVISION OF MEDICAL SERVICES

Volume 26 Number 2 www.dss.mo.gov/dms September 30, 2003

SPECIAL HIPAA BULLETIN

Provider Bulletin News: Due to budget constraints, paper copies of bulletins will no longer be distributed by DMS. Bulletins are now available only at the DMS Website address www.dss.mo.gov/dms. Please note new website address.

Bulletins will remain on this site only until incorporated into the provider manuals as appropriate, then deleted.

Missouri Medicaid News: Missouri Medicaid providers may sign-up to receive automatic notifications of all bulletins and other official Missouri Medicaid communications via e-mail. Providers and other interested parties are urged to go to the DMS website to subscribe to the e-mail list.

Table of Contents **Page**

MC+ MANAGED CARE

The information contained in this bulletin applies to coverage by the MC+ fee-for-service and Medicaid fee-for-service programs. The MC+ fee-for-service and Medicaid fee-for-service programs also provide coverage for those services carved out of the MC+ Managed Care benefit for MC+ Managed Care enrollees. Questions regarding services included in the MC+ Managed Care benefit should be directed to the enrollee's MC+ Managed Care health plan. Please check the patient's eligibility status prior to delivering a service.

HIPAA PREFACE

With the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards for transactions and code sets on October 16, 2003, the following information is being furnished as guidance for billing providers wishing to exchange electronic transactions with Missouri Medicaid. In order to comply with these national standards, significant changes for claims submission requirements must occur. While HIPAA mandates national standards for electronic claims transactions only, Missouri Medicaid will also apply the HIPAA transaction and code sets requirements to paper billing submissions. General changes for transaction and code sets requirements are included in this bulletin. For specific policy and billing information, providers should refer to applicable provider bulletins and manuals.

HIPAA does not require providers to conduct all of the national standard transactions electronically. Providers may process some transactions electronically and others may be submitted on paper. However, the HIPAA national standard transactions require that providers which choose to submit claims electronically must comply with the HIPAA format and content requirements.

TRANSACTION STANDARDS

HIPAA transactions are specific and distinct activities involving the electronic transfer of health care information for particular purposes. Under HIPAA Administrative Simplification, if an entity engages in one or more of the identified electronic transactions, the entity must comply with the national standard for that transaction. Under HIPAA, health care organizations that use HIPAA-defined transactions must use the ANSI ASC X12N and NCPDP standard formats. The NCPDP standard formats are used by retail pharmacies for drug claim transactions.

HIPAA IMPLEMENTATION GUIDES

Organizations responsible for adopting the national standards have developed implementation guides to assist covered entities and their business associates. The guides provide comprehensive technical details for HIPAA implementation as well as defining the specific activities related to each transaction, listing non-medical standardized code sets and providing directions for how data should be moved electronically.

These implementation guides provide instructions on how to program health care software according to HIPAA national standards. The Accredited Standards Committee (ASC) X12N Implementation Guides can be found at www.wpc-edi.com. All implementation guides and their corresponding Addenda are free of charge for download, however requests for paper copies do incur a cost to cover production and mailing.

IMPLEMENTATION OF TRANSACTIONS & CODE SETS

Providers must continue to follow existing billing instructions until otherwise notified in Provider Bulletins. To accommodate the size and complexity of the transaction and code set projects, Missouri Medicaid will implement the HIPAA standards in multiple phases. These phases may extend beyond the October 16, 2003, compliance deadline. Therefore, it is important for providers to review Provider Bulletins for detailed HIPAA billing instructions and implementation schedules.

TRANSACTION STANDARDS SCHEDULE

Transaction	Description	Implementation Date
ASC X12N 837	Health Care Claims • Professional • Institutional • Dental	October 16, 2003
NCPDP	Retail Pharmacy Drug Claims	October 16, 2003
ASC X12N 835	Health Care Claim Payment/Advice	October 16, 2003
ASC X12N 270/271	Health Care Eligibility Benefit Inquiry and Response	April 30, 2004
ASC X12N 276/277	Health Care Claim Status Inquiry and Response	December 29, 2003
ASC X12N 278	Health Care Services Review	April 29, 2004
ASC X12N 820	Health Care Plan Payment	October 16, 2003
ASC X12N 834	Health Care Plan Enrollment	October 16, 2003

COMPANION GUIDES

Billing providers wishing to exchange electronic transactions with Missouri Medicaid may view the X12N Version 4010A1 and NCPDP Telecommunication V.5.1 & Batch Transaction Standard V.1.1 Companion Guides on Missouri Medicaid's web page at www.dss.mo.gov/dms. To access the Companion Guides, select Missouri Medicaid Electronic Billing Layout Manuals; select System Manuals; select Electronic Claims Layout Manuals; select X12N Version 4010A1 or NCPDP Telecommunication V.5.1 & Batch Transaction Standard V.1.1 Companion Guide.

The Companion Guides provide information for populating data elements that are defined as payer or trading partner specific. In addition, the guides provide an explanation of how claims are processed within the Missouri Medicaid Management Information System (MMIS) when specific data elements are populated with each of the valid choices.

A Missouri Medicaid electronic biller must select one of two options for the exchange of electronic transactions. The first option is via an Internet connection at www.emomed.com

through an ISP (Internet Service Provider) of the biller's choice. The second option utilizes Sterling Commerce's Connect:Direct software to link directly to Verizon Information Technologies, Inc. Data Center. Refer to the Companion Guide for additional information concerning these two options.

Other Missouri Medicaid billing issues and policy information can be found in the Provider Manuals through the Division of Medical Services' website at www.dss.mo.gov/dms.

TRADING PARTNER AGREEMENT

In addition to selecting a connection method, a biller must complete a Missouri Medicaid Trading Partner Agreement form. The Trading Partner Agreement form is used to communicate trading partner identifiers and to indicate which transactions the biller wishes to exchange. The form is available at www.dss.mo.gov/dms or by calling the Verizon Help Desk at (573) 635-3559. Completed agreement forms can be sent via e-mail to verizonhelpdesk@momed.com or faxed to (573) 635-0316. If a biller does not have a current emomed submitter ID and wishes to send or receive files on the Internet, an Application for Missouri Medicaid Internet Access Account must be completed at www.medicaid.state.mo.us. If a biller has multiple provider numbers, a separate list must be attached identifying additional Receiver Demographic data.

ELECTRONIC CLAIM TRANSACTION TESTING

To test with Missouri Medicaid, the appropriate access account application and Trading Partner Agreement form must be completed and on file with Verizon Information Technologies, Inc. Following completion of these forms, the Verizon Help Desk notifies the biller of approval to send test transactions for those transactions indicated on the Trading Partner Agreement form. In addition, the biller's User ID and password are provided at that time. Until HIPAA is implemented into production, Missouri MMIS billers may be required to send an additional test file for each transaction before being moved to production. Refer to the Companion Guide for additional testing information.

ELIMINATION OF EXISTING FORMATS AND MEDIA (CONTINGENCY PLAN)

With the implementation of HIPAA national standards by Missouri Medicaid, the following non-HIPAA compliant methods of electronic claims submission will be phased out and will no longer be available for use by providers:

- Accelerated Submission and Processing (ASAP) System
- Wildcat Bulletin Board System (BBS)
- Direct Electronic File Transfer (DEFT)
- Direct Electronic Medicaid Information (DEMI)
- Fast Electronic Nursing Institution Xmission (FENIX)
- Magnetic Tape Billing (MTB)

The existing formats and media will be available during a grace period for providers unable to produce a HIPAA-compliant 837 transaction starting October 16, 2003. Providers may continue to bill current Missouri Medicaid formats and media during this grace period.

All providers wishing to bill Missouri Medicaid in paper format should refer to Section 15 – Billing Instructions for paper claim filing instructions in the appropriate provider manual.

NOTE: Providers who continue to bill claims to Missouri Medicaid using one of the non-HIPAA compliant electronic formats or media, as stated under Type of Service Section of this bulletin, should continue to bill using the appropriate TOS with the new procedure codes identified in the program-specific provider bulletins. For an example refer to Type of Service Section on page 6.

NURSING HOME PROVIDERS

For Nursing Home providers currently using the FENIX media to submit claims to Missouri Medicaid, a HIPAA-compliant direct data entry option very similar to FENIX will be available through the Internet. Providers are required to contact the Verizon Help Desk at (573) 635-3559 to obtain authorization for Internet submissions by completing the Application for Missouri Medicaid Internet Access Account. The website address for submitting claims using the direct data entry option is www.emomed.com. Providers are unable to access the site without proper authorization. If a Nursing Home provider plans to use an outside vendor to send batch files, a Missouri Medicaid Trading Partner Agreement must be completed and submitted to Verizon. Both forms can be found at www.medicaid.state.mo.us/.

REMITTANCE ADVICE

Missouri Medicaid will begin generating Health Care Claim Payment/Advice ASC X12N 835 transactions for claims adjudicated on or after September 19, 2003. As a remittance advice, the 835 transaction is used to transmit payment and data needed for posting by a provider subsequent to the adjudication of a claim. The remittance information consists of two separate levels. Level one consists of specific claim and service information. Level two consists of remittance information that is not specific to the claim and service contained in level one.

Since the 835 transaction can only be used to report data that affects the payment for providers' claims, non-claims processing information will no longer be reported on the remittance advice. The Missouri Medicaid-specific information which will be omitted from the remittance advice include 1099 information, suspended claims, status of attachments, TPL addresses, NAT claim information, Exception and EOB messages, type of service codes, and Medical Eligibility (ME) codes.

Providers will have the option of receiving the remittance advice either on paper or the 835 electronically, but not both. Providers will have the ability to switch from one media to the other and from paper to 835 and vice versa. A paper claim can be reported on the 835, and an 837 claim can be reported on a paper remittance advice. Providers must choose the type of media to receive the 835 on the Missouri Medicaid Trading Partner Agreement. Please refer to the ASC X12N 835 Implementation Guide for additional information.

ADJUSTMENT REASON & REMITTANCE REMARK CODES

With the implementation of the ASC X12N 835 Health Care Claim Payment/Advice, Missouri Medicaid will no longer report Missouri Medicaid-specific Explanation of Benefits (EOB) and Exception message codes on the remittance advice. As required by HIPAA national standards, administrative code sets Claim Adjustment Reason Codes and Remittance Remark Codes

will be used. The Claim Adjustment Reason Codes identify the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment. The Remittance Remark Codes provide either claim-level or service-level messages that cannot be expressed with a Claim Adjustment Reason Code. Both code sets may be used in the ASC X12N 835 Health Care Claim Payment & Remittance Advice and the ASC X12N 837 Health Care Claim transactions.

SPLIT CLAIM

An 837 electronic claim submitted to Missouri Medicaid may, due to our adjudication system requirements, have service line(s) separated from the original claim. This is commonly referred to as a split claim. Each portion of a claim that has been split will be assigned a separate claim internal control number and the sum of the service line(s) charge submitted on each split claim becomes the split claim total charge. Currently, within Missouri Medicaid's MMIS, 28 service lines per claim are processed. The 837 Implementation Guides allow providers to bill a greater number of service detail lines per claim.

All detail lines that exceed the size allowed on our internal detail record will be split into subsequent detail lines. Any claim that then exceeds the number of detail lines allowed on our internal claim record will be used to create an additional claim.

CLAIM ATTACHMENTS

The Standards Development Organization, Health Level Seven (HL7) is currently working on claims attachment standards that may be named as the HIPAA standard for claims attachments. Missouri Medicaid has been working with the Claims Attachment Sub Workgroup of the National Medicaid EDI HIPAA Workgroup (NMEH) to develop claim attachment standards specific to Medicaid's needs and submit the needs to HL7 for consideration.

Until the adoption of the national claims attachment standards, Missouri Medicaid is working to develop a process for submitting the required claim attachment information in paper form while allowing providers to submit the claim electronically. Until that process is implemented, Missouri Medicaid providers must continue submitting paper claims with the required attachment, unless the attachment can be submitted via the Internet.

Specific claim attachment information can be found in Section 14 of the appropriate Provider Manual and Section 23 through the Division of Medical Services' website at www.dss.mo.gov/dms.

TYPE OF SERVICE

With the implementation of HIPAA national standards, type of service (TOS) will no longer be a valid code set. Type of service *must not* be included on any type of claim **received by Missouri Medicaid** (other than the non-HIPAA compliant formats and media as defined above) **on or after October 16, 2003**, regardless of the date of service being billed. Claims submitted to Missouri Medicaid must reflect an appropriate modifier with a procedure code when billing for the services defined below. For example, prior to October 16, 2003, when billing for an assistant surgeon's services, a procedure code was submitted with TOS 8. Effective on or after October 16, 2003, when billing for an assistant surgeon's service, a procedure code must be submitted with modifier '80', even if the date of service is prior to October 16, 2003. Failure to do so may result in claim denial.

Modifier	Definition
26	Professional Component
54	Surgical Care Only
55	Postoperative Management Only
80	Assistant Surgeon
AA	Anesthesia service performed personally by anesthesiologist
NU	New Equipment (required for DME service)
QK	Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals
QX	CRNA service; with medical direction by a physician
QZ	CRNA service; without medical direction by a physician
RP	Replacement and Repair (required for DME service)
RR	Rental (required for DME service)
SE	State and/or federally funded programs/services
SG	Ambulatory Surgical Center (ASC) facility services
TC	Technical Component
UC	EPSDT Referral for Follow-up Care (required if EPSDT referral made)

NOTE: Providers who continue to bill claims to Missouri Medicaid using one of the non-HIPAA compliant electronic formats or media, as stated under Elimination of Existing Formats and Media (Contingency Plan) Section of this bulletin, should continue to bill using the appropriate TOS with the new procedure codes identified in the program-specific provider bulletins.

LEVEL OF CARE MODIFIERS

The Centers for Medicare and Medicaid Services (CMS) in conjunction with the National Editorial HCPCS Panel has approved and released thirteen (13) Medicaid Level of Care descriptive modifiers. These modifiers are defined by each State's Medicaid agency and should not be submitted to or used by any other payor. The following chart reflects Missouri Medicaid's definitions for the modifiers. Providers should refer to program-specific bulletins and manuals for instructions on the use of these modifiers.

Modifier	Definition
U1	Community Support Waiver
U2	Consumer-Directed
U3	Residential Care Facility (RCF) Setting
U4	AIDS Waiver
U5	Physical Disabilities (PD) Waiver
U6	Independent Living (IL) Waiver
U7	Sexual Assault Findings Examination (SAFE) and Child Abuse Resources Examination (CARE) Network Services
U8	Service Provided in Home Setting
U9	Diabetes Self-Management Training Services
UA	Lead Related Services
UB	Exception Process Service
UC	EPSDT Referral for Follow-up Care
UD	Licensed Professional Counselor

CODE SETS

The HIPAA code set regulations establish a uniform standard of data elements used to document the procedures performed during health care services. Missouri Medicaid-specific local codes will be replaced with the standard codes. The proper usage of the standard code sets is as follows:

- For inpatient hospital claims with dates of service on or after October 16, 2003, providers must submit the appropriate surgical procedure using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), Volume 3, procedure codes to indicate the surgical procedure performed and the appropriate accommodation revenue codes when billing any claim format or media.
- For outpatient hospital claims with dates of service on or after October 16, 2003, providers must submit the appropriate Current Procedural Terminology (CPT) or Health Care Procedure Coding System (HCPCS) procedure codes and the appropriate Revenue Codes for outpatient facility charges when billing any claim format or media.
- For hospice claims with dates of service on or after October 16, 2003, providers must submit the appropriate hospice Revenue Codes for hospice services when billing any claim format or media.
- For professional claims with dates of service on or after October 16, 2003, providers must submit the appropriate CPT or HCPCS procedure codes when billing any claim format or media.
- For dental claims with dates of service on or after October 16, 2003, providers must submit the appropriate:
    - Current Dental Terminology, Fourth Edition (CDT-4), HCPCS or CPT procedure codes when billing on the ADA, 99 Version 2000 claim form;
    - CDT-4 codes only when billing on the ASC X12N 837, version 4010A1 Dental format or the Internet Dental Claim; or
    - CPT or HCPCS codes only when billing on the ASC X12N 837, version 4010A1 Professional format or the Internet Medical Claim.

For outpatient hospital and professional claims with dates of service on or after October 16, 2003, providers may submit up to four modifiers with the applicable procedure code. To submit the additional modifiers, providers must bill as follows for these formats:

- Paper CMS-1500: Providers bill all modifier values immediately following the procedure code in Box 24D without any spaces.
- Paper Outpatient UB-92: Providers bill the first two modifiers values immediately following the procedure code in FL (Field Locator) 44 without any spaces. If there are more than two modifiers, remaining modifiers are billed in FL 49 of the same service line without spaces.
- Dental Claim Formats and Media: Modifiers should not be submitted with any procedure code for any dental service in any claim format or media.
- ASC X12N 837, Version 4010A1 Professional and Institutional: Providers should refer to the 837I and 837P Implementation Guides.

Providers should refer to the appropriate provider bulletins and manuals for modifiers applicable to specific Missouri Medicaid programs.

REPLACEMENT OF LOCAL CODES

Section 532 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) authorizes the Secretary of Health and Human Services to allow the continued use of HCPCS Level III (local) codes through December 31, 2003. CMS has determined that the term, HCPCS Level III codes, as used in this BIPA provision, applies both to the codes that Medicare has approved for local contractor use and to the state Medicaid agencies' local codes. Therefore, state Medicaid programs may, at their option, continue to use the local codes through December 31, 2003.

Missouri Medicaid is in the process of replacing all local codes. Providers should refer to the DMS website at www.dss.mo.gov/dms for Provider Information Bulletins detailing the replacement of local codes.

ICD-9 DIAGNOSIS CODE

HIPAA standards require the use of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), Volumes 1 & 2, diagnosis codes to report a patient's diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for an encounter or visit. The ICD-9-CM is composed of codes with 3, 4, or 5 digits. Codes with 3 digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digit which provides greater specificity. A code is invalid if it has not been coded to the full number of digits required for that code. Providers must report the patient's diagnosis to the greatest level of specificity to ensure payment of the claim by Missouri Medicaid.

PLACE OF SERVICE CODES

HIPAA standards require the use of the Centers for Medicare and Medicaid Services (CMS) Place of Service codes to specify the entity where a service(s) was rendered. Effective October 16, 2003, for all dates of service, providers must bill the appropriate place of service. Providers should refer to the provider manuals for appropriate use of the Place of Service codes. (See Attachment A for a complete list of Place of Service codes.)

HELPFUL WEBSITES FOR HIPAA INFORMATION

To obtain additional information concerning the electronic data interchange and HIPAA, DMS recommends you consult the following web sites:

- The Department of Health and Human Services (HHS) Web site contains the final rules, Notices of Proposed Rule Making (NPRM) and a Frequently Asked Questions (FAQ) section. http://aspe.osdhhs.gov/admnsimp/

- The Centers for Medicare and Medicaid Services (CMS) is the Federal agency that administers Medicare, Medicaid and State Childrens Health Insurance Programs. http://www.cms.gov/

- Washington Publishing Company publishes the Accredited Standards Committee (ASC) X12 Implementation Guides. The HIPAA Guides are free of charge for download, however, requests for paper copies do incur a cost to cover reproduction and mailing. The Adjustment Reason Codes and Remittance Remark Codes are also available on this website. http://www.wpc-edi.com

- The Data Interchange Standards Association (DISA) supports the Accredited Standards Committee (ASC) X12 organization. ASC X12 is responsible for developing many of the transaction and code set standards which can be accessed through DISA. http://www.dis.org/

- Health Level 7 (HL7) is one of several ANSI-accredited Standards Developing Organizations (SDOs) operating in the healthcare arena. HL7 develops specifications, the most widely used being a messaging standard that enables disparate healthcare applications to exchange key sets of clinical and administrative data. http://www.hl7.org

- The National Council for Prescription Drug Programs (NCPDP) is the standards development organization responsible for developing retail pharmacy standards. The Workgroup for Electronic Data Interchange (WEDI) is an industry task force created to streamline health care through standardized electronic formats and implementations. http://www/ncpdp.org/

- The Workgroup for Electronic Data Interchange Strategic National Implementation Process (WEDI SNIP) is an industry group tasked with coordinating a collaborative health care industry-wide adopted process that achieves implemented national standards and furthers the development of future standards. http://www/wedi/org/

- The Association For Electronic Health Care Transactions (AFEHCT) is the industry's lobbying organization. AFEHCT closely monitors the implementation progress of healthcare entities and works to promote the efforts that Congress and the White House have made, on behalf of healthcare industry, to encourage cost efficiencies through the Administration Simplification rules as stated in HIPAA. http://snip.wedi.org/

- The National Committee on Vital and Health Statistics (NCVHS) is the public advisory body to the Secretary of Health and Human Services (HHS) in the area of health data and statistics. http://www.ncvhs.hhs.gov/

- The National Uniform Claim Committee (NUCC) was created to develop a standardized data set for use by the non-institutional health care community to transmit claims and encounter information to and from all third parties. http://www.nucc.org/

- The National Uniform Billing Committee (NUBC) was formed to develop a single billing form and standard data set that could be used nationwide by institutional providers and payors for handling health care claims. http://www.nubc.org/

Attachment 1

Place of Service (POS) Codes

POS Code	POS Name	POS Description
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility*	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home*	Congregate residential facility care setting for children and adolescents in state custody that provides some social, health care, and educational support services and that promotes rehabilitation and reintegration of residents into the community
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.

POS Code	POS Name	POS Description
20	Urgent care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A free-standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41	Ambulance – Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

POS Code	POS Name	POS Description
49	Independent Clinic*	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by and under the supervision of a physician.
52	Psychiatric Facility-Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-0 based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility*	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.

POS Code	POS Name	POS Description
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
71	Public Health Center**	A facility maintained by either a State or local health department that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other Place of Service	Other place of service not identified above.

* New Place of Service code, effective October 1, 2003.
** Revised Place of Service code, effective October 1, 2003.

Provider Communications
(800) 392-0938
or
(573) 751-2896